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WESTERN CANADA MEDICAL JOURNAL

VOL. III. MARCH, 1909. No. 3

ORIGINAL COMMUNICATIONS.

*SOME NOTES ON THE SURGERY OF THE LACHRYMAL SAC.

BY

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Inflammation of the tear sac, Dacryocystitis, is very rare as a primary condition. It is also rare as secondary to a conjunctivitis. It is generally believed to be due to an extension of the inflammation from the inferior meatus. The inflammation of the tear duct causes an engorgement of the venus plexus of the duct and sac and prevents free drainage. An accumulation of the fluid in the sac then occurs. This increased amount of fluid acting as an irritant causes an increased mucous secretion and mucous inflammation with the formation of pus; and thus a dacryocystitis is produced. Pressure may empty the contents of the sac into the nose but more commonly it regurgitates into the conjunctival sac.

A large number of bacteria have been found in the secretion from the sac. Most of the earlier reports described staphylococci and streptococci, whilst in later reports pneumo-

*Read before the British Columbia Medical Association, August 21, 1908.

cocci were found, though seldom in pure culture. Those more rarely found have been the bacterium coli, bacillus pyocyaneous and various unclassified bacilli, xerocius bacilli and the diplobacillus of Morax-Axenfeld.

The presence of trachoma of the lachrymal canal has been proven by Basso (Annali di Ottalmologia 7, 8, 9; 1906 Translation Annals of Ophthalmology 1907, u. 552).

I have been unable to find in the reports a single case of dacryocystitis as a complication of gonorrhoeal conjunctivitis.

Rollet (Soc. Franc d'Ophtal., May 1906, Translation Annals of Ophthalmology, 1906, p. 598) reports two cases of primary epithelioma of the sac and one case secondary. In adults lachrymal troubles seem to be more frequent on the left side than on the right, for out of ninety-five cases, G. Hirsch (Annals of Ophthalmology, 1907, p. 619) has found the left side affected in 33; the right in 20, both in 42.

Clinically, in disease of the tear sac one finds in the very early cases simply an epiphora, produced by an alteration in the mucosa of the sac and duct. In the more advanced cases one has a chronic dacryocystitis with secretion, which by pressure over the sac may be thrown into the conjunctival sac. In other cases one finds a tumor over the region of the sac. In other cases where there is obstruction in the duct and also in the canaliculi one finds the tumor more tense and the contents by pressure may not be forced out through the canaliculi and may or may not be pressed down into the nose.

In children, E. Jackson (Oph. Rec. Vol. XVI., page 321) "Believes that lachrymal obstruction showing immediately "after the birth or as soon as the secretion of the tears has "begun, is due to the delayed development of the nasal end "of the lachrymal duct unless disease in the nose or parts "adjoining the lachrymal passages offer a different explana-"tion. He refers to autopsies made on newborn children by "de Vlacovich and Rochon-Duvigneaud who reported cases in "which the orifice connecting the lachrymal drainage canal "with the nose had not been opened. As the lachrymal secre-"tion is not noticeable for several weeks after birth; no func-"tional demand is made upon the lachrymal passages, and in "many cases of delayed opening of the duct into the nose no

"symptoms are noticed as the opening occurs in time to meet "any demands upon it."

The prognosis in all affections of the lachrymal passages in children is much better than in adults. In these conditions I make it a rule to first examine the child under a general anaesthetic. I instruct the mother to press out the contents of the sac once or twice a day, and then to use a mild collyrium of boracic acid, zinc sulphate or argyrol, and once every two or three days I irrigate the sac with one of the above solutions. Total extirpation of the sac is not often necessary in these cases. As a rule the condition becomes well and often spontaneously. In nearly all of the text-books, in dealing with the treatment of dacryocystitis the authors, with great regularity, advise a mild collyrium, then a slitting of the canaliculus, probing and syringing, and as a last resort the destruction of the sac by caustics or the radical operation. Modern operators do not thing favorably of much probing. The repeated passing of large probes Risley designates as cruel surgery, considering the crushing they occasion. Very small probes are apt to make a false passage, and large ones injure the mucosa. Parsons considers the method of treatment generally practiced by probes only to condemn it. In some cases, if the case has never been treated with probes, syringing, if properly carried out, will do well. Syringing must be perserved in and is most successful in early cases or where there is only epiphora. Care, however, should be exercised in the use of the syringe. F. Park Lewis (Oph. Rec., Dec., 1907) reports a case of blindness following the injection of Protargol into the lachrymal sac. It was a case of abscess of the sac in which a fistulous opening remained for the discharge of pus. The ruptured sac had allowed the protargol to enter the orbital tissues, which intensified a cellulitis already existing and involved the optic nerve. Staining of the skin of the lower lid by injection of Argyrol solution into the lachrymal sac has been reported, and I saw a case a few weeks ago in which Argyrol solution had been used to irrigate the sac and in which there was a marked staining of the lower eyelid, but the patient informed me that it was gradually disappearing.

Darier (Die Ophthalmologische Klinic, Dec. 20, 1905 Transl., Annals of Ophthalmology, 1906, p. 319) has tried hypodermic injections of Doyen's Antistaphylococcus serum in three cases of chronic Dacryocystitis. Two cases were promptly cured and one failed to respond, although sufficient time, he thinks, was not allowed. He used 2½ to 5 cc. of the serum each time, and in the first case six injections in all were tried at intervals of a day or two. In the second case three injections were given. The only benefit one can obtain by the use of a serum or vaccine in a case of dacryocystitis is in clearing up the pus laden secretion from the sac. Believing that the elastic and muscle fibres that enclose the sac are more or less degenerated and thus rendered inactive in cases of chronic dacryocystitis, the mechanism of the excretion of the tears becomes very much interfered with, and although one may have a perfectly free passage through to the nose after the secretions have become sterile, there will always remain the possibility, and indeed probability, of a fresh infection of the sac taking place, and especially so in cases where there is some disease of the nose present. Serum or vaccine treatment, I think, has a very limited field of usefulness in these cases, certainly only in the very early cases before there is any dilatation of the sac.

To summarize, we may say in diseases of the lachrymal sac that produce simply an epiphora, syringing the sac will probably be all that will be required. On the other hand, should we have a chronic Dacryocystitis with purulent secretion to deal with, the radical operation of total extirpation of the sac is urgently called for. Experience with that operation as practiced now, shows that we have at hand a simple and efficient operation. Experience also shows that the absence of the lachrymal sac produces no ill effects. In cases of chronic dacryocystitis the operation of total extirpation is urgently called for in eyes frequently exposed to injury, e. g., in mechanics, miners, farmers, stonecutters and in the insane (De Schweinitz). Axenfeld states that nearly 80 per cent. of cases requiring the removal of the sac are in the working class, and that in nearly 35 per cent. of cases of dacryocystitis permanent dense opacities of the cornea result. This opera-

tion is also imperative in cases of ulceration of the cornea, hypopion keratitis, and in cases with disease of the bony walls of the canal and also as a preliminary to operations on the eyeball, e. g., cataract operations, or any operation in which the eyeball must be opened. Also in cases of malignant growth of the sac and lachrymal fistula. A lachrymal abscess should be freely incised and the cavity drained. Several weeks after the inflammation has subsided, the sac should then be removed. Scrupulous attention to the nose and naso pharynx is imperative in all cases, and any diseased structures should receive appropriate treatment.

Brewerton (The Ophthalmoscope, April 1906) in reviewing the history, found that destruction of the lachrymal sac dated back at least eighteen hundred years. The Cautery seems to have been quite popular with those ancient surgeons. Platner, in 1724, did an extirpation of the sac, and combined it with the formation of a false passage into the nose. Rosas tried to revive this operation in 1830, Hatter in 1867, Berlin in 1868 and Schreiber in 1881.

Wintersteiner (Wiener Klinische Wochenschrift, Nov., 1906, Trans. Anals of Ophthalmology, 1907, p. 342) in his experiments with Tropacocain, Holocain, Eucain, Stovain, Alypin and Novocain in Ophthalmology, he still believes cocain to be the best local anaesthetic. General anaesthesia for this operation is preferred by many surgeons. In all of my cases, so far, I have used local anaesthesia. A one per cent solution of cocain with afew drops of adrenaline chloride solution is injected under the skin in the region of the sac, and I have found it quite satisfactory in every way. Should I ever be obliged to use a general anaesthetic I would, if possible, have the ether given per rectum. An excellent method of giving a general anaesthetic in many operations about the head. A method, of course, that can be used only in selected cases, and only after very careful preparation for the patient.

The instruments for the operation of extirpation of the sac consists of a small scalpel, forceps, a small curved, blunt-pointed scissors, a small sharp spoon curette, Muller's retractor, needles and silk. Immediately before doing the operation, I irrigate the sac with a boracic acid or Argyrol solution

or a mild bichloride solution.

The incision is made in a curved direction, about 10 mm. in length, and beginning just above the internal palpebral ligament. The crest of the lachrymal bone being first outlined with the finger, the incision is then carried down to the bone, and by separating the lips of the wound the sac comes into view and may be recognized by its blueish color. Muller's speculum is them inserted, but it is not absolutely necessary in all cases. Beginning at the nasal side the sac is carefully dissected out, and may best be done with the blunt-pointed scissors. With this instrument only, the upper end, posterior surface, and outer side of the sac are carefully freed. The sac is then held with the forceps, the scissors pushed down behind the sac and the duct, which is cut through as low as possible. The opening of the naso lachrymal duct is then curetted with a sharp spoon.

Bleeding is often smart during the operation, but can be easily controlled with pledgets of cotton saturated in a sterilized solution of Adrenalin chloride and weak cocain solution. Two or three silk sutures close the wound. A pad of absorbent cotton is placed directly over the wound and a pressure bandage applied for the first few days, and the sutures to be removed on the fifth day. I have never thought it necessary to cauterize the canaliculi as advised by R. C. Holmes. If epiphora persists for a reasonable time after the operation, removal of the palpebral portion of the lachrymal gland may be performed. In spite of this procedure, epiphora may persist for a time. Usually a mild collyrium to be used for a few days will be found necessary. Statistics show that failures are due mainly to faulty technique.

In some cases a careful dissection might be made to expose the sac without dividing the internal palpebral ligament, but that would be a more difficult operation than by the open method, and one that would have no more advantages. A point of practical importance in the after treatment is to advise against the use of the handkerchief in a violent manner especially—for obvious reasons. It is well-known that, normally, evaporation is sufficient to carry off the excess of fluids, and that the Epiphora of Dacryocystitis is due to the associated Conjunctivitis from the irritation of the discharge from the sac.

*THE URGENT NEED OF IMPROVED HOSPITAL ARRANGEMENTS IN COMBATING BONE AND JOINT TUBERCULOSIS

BY

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While for many years it has been universally recognized that fresh air and sunlight are the most important of all agencies in the treatment of pulmonary tuberculosis, and while a large literature dealing with various aspects of this matter has long been available, the fact that these same agencies are equally important in the management of surgical tuberculosis does not seem even yet to have fully taken hold of either the medical profession or society.

At the annual meeting of the American Orthopedic Association in Philadelphia in 1902 the writer presented a paper on the General Management and Constitutional Treatment of Tuberculosis of Bones and Joints, in which special reference was made to the vast usefulness of tents in the management of chronic bone and joint troubles of tubercular origin. In this paper, which was published in the Therapeutic Gazette, July 1902, it was pointed out that in all the multitude of papers on tuberculous bone and joint disease to be found in the 14 volumes of the Transactions of the American Orthopedic Association, scarcely a reference to the importance of fresh air and sunlight could be found, and that nearly all the standard text books on both orthopedic and general surgery were equally silent.

During the past five or six years considerable additions to the literature of this subject have been made, and an in-

*Read before the Winnipeg Medico Chirurgical Society

creasing number of orthopedic children's and general hospitals are giving practical recognition to the fact that the class of cases under consideration cannot be adequately treated in ordinary hospital wards; nevertheless it is true that society has as yet merely trifled with this matter, that all existing provision is wofully inadequate, and that in scores of hospitals practically no attempt is made to secure a special environment for patients affected with the various forms of surgical tuberculosis.

The writer' conception of the proper hospital requirements for this class of patients can perhaps be best set forth by the following quotation from his former paper above referred to:

"Every agency should be employed which will fortify the patient's constitution, augment his general vigor and increase the resisting power of his tissues and it may be claimed that of all the various means to these important ends at our command the most valuable are fresh air and sunshine. The more nearly the patient can be brought to a continuous outdoor life, with the inconveniences of such a mode of living eliminated, the better. The best means of securing this will depend upon circumstances. The ideal method is to place the patient in practically the same kind of environment as is found in the best sanitoria for pulmonary tuberculosis. In fact, sanatorium methods are almost as indispensable to the best results in bone and joint tuberculosis as in phthisis. Saying this is equivalent to claiming that the vast majority of poor patients cannot properly be treated in their own homes, and that even in the homes of the well-to-do special arrangements are necessary, and such is the case. The poor should be treated, at least for a time, in hospitals—not in ordinary hospital wards, but in hospitals with special provision for the requirements of tuberculous patients in regard to sunshine and fresh air. I know of few more discouraging problems than the attempt to treat successfully and guard against relapse the immense number of tubercular joint cases seen in the orthopedic clinics of the hospitals in large cities. The depression of vital powers which results from insufficient and unsuitable food is accentuated by breathing the vitiated atmosphere of small, close, dirty rooms, and is multiplied al-

most indefinitely by the general ignorance, wretchedness, poverty vice, and bad heredity of the submerged classes in our large centres of population. The only hope of giving such patients a fair chance in the conflict with such a foe as tuberculosis consists in securing for them, for a time at least, proper hygienic surroundings, and this for the purpose of enlightening them as to their own requirements not less than for the immediate beneficial effect of the improved environment. The writer is not blind to the practical difficulties in the way of providing suitable hospital accommodation during lengthened periods for the multitude of patients with chronic tubercular joint affections; nevertheless, it is the duty of the medical profession to arouse attention to the existing need, and to point out that civilization and philantropy have thus far failed adequately to provide for it. The requirements will not have been met until the poor who suffer from these affections can command the advantages of sanitorium methods, at least during the acute stage of the disease and in the winter season. In the convalescent period and during summer they can be treated fairly well as out patients, for a great many cases, even among the poor, do reasonably well in the warm season when for their own comfort they are compelled to open up their houses, live out-of-doors to some extent, and get all the fresh air possible. My observations have convinced me, however, that relapse and aggravation of Pott's disease, hip-joint disease, and other chronic tubercular joint troubles are especially apt to occur during the latter part of the winter, the reason being that the patient's general health and resisting power have been greatly reduced by months of residence in close ill-ventilated rooms. In case of the very-poor the only sure way of preventing this deterioration of general health and its resulting unfavorable influence upon the joint affection is to provide for them a suitable environment during the inclement season."

The limits of this paper forbid any extended reference to the commendable efforts which are being made in various places to improve the hospital environment of the unfortunate sufferers from tuberculosis of bones, joints, glands, etc. It is, however, a hopeful and encouraging sign of a coming awaken-

ing, that seaside homes, mountain homes, day camps, roof gardens, tent wards and sunny verandahs are in increasing number being placed at the disposal of the surgeon to aid him in his warfare against disease which, at least in many instances, must be conquered at all be conquered as much by fresh air and sunshine as by surgical skill. From all places where such improved surroundings for this class of patients are being used, come the most gratifying reports of more satisfactory progress under the better conditions.

In a paper published in the Pennsylvania Medical Journal January 1906, Dr. H. Augustus Wilson, of Philadelphia, writes as follows:—"I have for many years watched the improvement that occurs in patients sent to the seashore and have witnessed recoveries that seemed impossible. The close proximity of Atlantic City to Philadelphia, has enabled me to keep patients under my personal observation while they spent many months at the seaside with the attainment of results in almost incredible contrast to those kept in Philadelphia. It has been absolutely convincing to me to see tuberculosis of the spine and of the various joints recover without deformity or other evidence of the former affection. Sinuses that have dribbled foul pus for many years have closed spontaneously, and upon the patient regaining sound health have remained closed..... I have sent patients to Atlantic City in what I firmly believed to be the last stages of ameloid degeneration and have seen them return with healthy vigor that subsequently enabled them to resume the activity of school life."

Reports quite as favorable as those referred to by Dr. Wilson as resulting from seaside residence have come from various inland sources where out-door life has been tried in the same class of cases. My personal experience for several years in Toronto in the use of tent wards for patients with bone and joint tuberculosis was of an exceedingly favorable character. I am convinced, however, that improved hospital facilities for intern patients will not alone meet the need. These must be supplemented by an efficient and interested out-patient service, and the machinery of the out-patient department should include some adequate system of home visita-

tion, by nurses or competent assistants, of patients who for any reason fail to present themselves regularly for examination for as long a period as the surgeon may consider supervision necessary. Further, there should be such relations between the ward service and the out-patient department as to secure something approaching continuity of surgical responsibility in regard to each of these chronic cases. That patients of the class under consideration suffer distinct disadvantage through being changed from one surgeon who is familiar with the case to another who is not open to question. One of the commonest hospital experiences may be thus presented: A child with Pott's disease, or with tuberculosis of hip, knee or ankle, is treated for months in the hospital wards until recovery is sufficiently advanced to warrant discharge. He leaves the hospital wearing a brace and with instructions to report at the out-patient department. There he meets a different surgeon who knows nothing about the acute stage of the illness beyond what can be gleaned from the patient or his parents, and who is unacquainted with the opinion held by the ward surgeon as to the details or convalescent treatment and the length of time that supervision should be continued, and is consequently not in the best position to do justice to either the patient or himself. The parents are ignorant and cannot understand the importance of prolonged supervision and soon discontinue returning the child, and for a few months the case is lost sight of. As soon as the patient's brace falls into disrepair, and frequently before that time, it is discarded by the parents on their own responsibility. Relapse takes place, and presently the patient is again an inmate of the wards of the same or another hospital, this time frequently under a third surgeon; and in all probability he will have to remain a ward patient for a longer time than in the first instance. This experience of alternate convalescence and relapse is sometimes repeated several times, the patient being intermittently in hospital for a number of years. Had there been an ideal environment during the period of hospital residence in the first instance, followed up by supervision which would assure a continued knowledge of the patient together with proper provision for continuity

or surgical responsibility, many of these disheartening experiences would be avoided. Under improved conditions relapses would be less frequent, recoveries with far less average disability would be secured, lives would be saved, many patients who now become hopelessly crippled or permanently invalided would be restored to health, the hospitals could handle a larger number of patients by reason many beds being set free which under present conditions are occupied for indefinite periods by chronic and relapsed cases, and the economic gain would be large. Could conditions more in keeping with modern knowledge be provided, not only would a vast army of patients be benefited to a degree which is impossible under existing circumstances, but an invaluable educating influence upon both the public and the profession would incidentally result. The patients and their friends would learn the importance of fresh air in combating tuberculosis of bones and joints without being directly taught; and the undergraduate in medicine would get such a conception of the true relation of constitutional and surgical measures in the management of this class of cases as he cannot by any possibility absorb under present conditions, where he daily beholds his teachers carrying on treatment almost wholly by surgical and mechanical means alone, and, in short, teaching one thing and practicing another. It has become a common experience with the writer, when giving to his students a clinical lecture on a case of joint tuberculosis, to emphasize the first importance of a favorable environment having special reference to out-door life and sunlight; and then in the same breath to apologize for not using these means in the case under discussion for the simple reason that the hospital did not provide the requisite kind of accommodation! A sorry spectacle, surely!

The need of improved arrangements for the care of patients suffering from surgical tuberculosis is peculiarly urgent in Manitoba. This is due chiefly to the character of our climate. Coming to this city after conducting an orthopedic practice in Toronto for a number of years, the writer has experienced an ever-deepening conviction that the difficulty of successfully managing bone and joint tuberculosis is dis-

tinctly greater here than in his former field of work, chiefly because the greater severity and longer duration of the winter in this province makes the always difficult problem of fresh air still more intricate and complicated There is a large foreign population, many of whom are both poor and ignorant, and surgical tuberculosis is very prevalent. Under these combined conditions it is not surprising that patients with joint tuberculosis not infrequently spend more than half the year not merely within doors, but in rooms, which are small, crowded, foul, unventilated, poorly lighted, and infested with vermin; and further, because of poverty or ignorance, or both, are fed with food which, if not actually insufficient in amount, is at least of such kind as could not possibly provide suitable nourishment for healthy tissues, to say nothing of increasing the resisting power of tissues which have proved vulnerable to the bacillus of tuberculosis. The poor with surgical tuberculosis can never be adequately handled in this province, or in any other, until either State or private philantropy, or both together, shall set about a vastly more comprehensive solution of the problem than has been attempted.

DISCUSSION ON WESTERN RECIPROCITY

A general meeting of the profession was held in the Medical Library, February 20th, to hear an address by Dr. Brett, of Banff, upon "Some Aspects of the Medical Profession in the West." Dr. Todd took the chair, and after a few appropriate remarks on Reciprocity, introduced the speaker.

Dr. Brett said that as a visitor from Alberta he was glad to have an opportunity of exchanging opinions and greetings. Continuing, he said: "I am very glad to say that as far as Alberta particularly is concerned, we are pretty free from the dissension and rancour we so often find among members of the profession. We also have been singularly free in Alberta from quacks and illegal practitioners. That has been accomplished by the vigilance of the Council in that Province. The Council regard it as a duty to protect the members of the profession in the different portions of that Province, so that whenever they are made aware of any illegal practice, steps are taken immediately to secure evidence and, if possible, to secure prosecution and a verdict. I think probably that has more to do with arousing interest among members of the profession generally than any other means you can take. I think I may say also that there is no other province where a livelier interest is taken in association work than in Alberta. We have medical associations in Edmonton and Calgary; both very lively institutions, and our Provincial Medical Association is really quite a live institution. We had the pleasure of meeting representatives from your city last year and appreciated their papers very much.

I attribute the interest the medical men take in association work in Alberta more particularly to the protection which has been given them by the Council, than to any other means. One thing I, however, regret: just before I came away, I note that the legislature had gone into the business of making parent doctors. That was attempted at the first session of the legislature and a delegation from the Council immediately went to Edmonton and pointed out that the Province should

not start making doctors by legislation, but should have confidence in the profession to let them attend to that particular kind of legislation, but this year, notwithstanding their promises, they licensed one man who had no qualifications for registration, and I fear probably did not have the ability to face an examination. The Council immediately took steps to try and prevent it, but notwithstanding all they could do, the bill went through. It is in matters of that kind that you can arose much interest in the profession. Now, so far as Alberta is concerned, they are strongly in favor of bringing about a confederation of the provinces for the purpose of giving one examination and issuing one license. (Applause).

We have discussed the question of one examination. In fact, we were very much impressed with the utility of Dr. Roddick's bill and I know that on that occasion anyone who could do anything had both hands up in support of the bill he proposed. Unfortunately it did not become law, but we hope it will. The Northwest Territories, as they were then, thought that if the Roddick bill did not go through, they would be very much better off if they were joined with Manitoba and British Columbia, than if each one held an examination.

I think there are a number of men here who have been for years conducting examinations, and they will realize that no matter how conscientious or how able you may find a number of medical men in a province, if they have not had some training in holding examinations; if they had not some experience along that line, they wil not give as good, as searching an examination, as those who are more particularly versed in that direction, and we also realize that oftentimes there were candidates who got through when it would probably have been better if they had not. Sometimes an examiner does not frame his questions to find out what the applicant knows, as much as to find out how little he knows. The questions are not broad enough. They do not cover the ground in the right way to ascertain really the general knowledge possessed by the candidate. So, realizing that, and feeling that it would advance the profession in the West if we adopted something along the lines of the Roddick bill, we are

in favor of some such scheme. I would point out to you that the laity do not have the high opinion of the profession that they might have. Probably their reasons are not well founded, but I have often heard the question asked, "How is it that a graduate from McGill or Toronto Universities, when he comes up here, has got to pass an examination?" Just think what answer you can give to that question. I know I am often puzzled to give an answer that I think will satisfy the inquirer, because I cannot satisfy myself. (Applause), I can only say they have got a law such as that in other provinces and I don't see why we should not have one. There is the only answer after all. Because they do wrong we have to follow suit. I don't know of any other answer. They answer, "Well, why don't you pull together? You must have some reason, and it occurs to me that it is because you want the money or some personal benefit." Those are the questions and those must be the conclusions some at any rate must come to when they cannot get a more satisfactory answer.

A few days ago I had a letter from a lady in Dublin asking me if I would be good enough to tell her if there were any good doctors near Edmonton, because she had a daughter who was going out who was not very strong, and she did not want her to go out unless there was some good physician near that place. Well, it seems to me that if we had a federation of the provinces in Western Canada and established a good, central examining board which would grant licenses to graduates enabling them to practice in any of the four provinces, we would arouse the people in the East and it would also become more or less public on the other side of the water, and when the laity ask the question, "What kind of doctors have you got there?" we could say we have got that what does not exist anywhere else in Canada. We have got a Board representing four great provinces and we take good care that no one is licensed to practice in those provinces unless they are very well qualified to do so. That would be doing a great deal for the profession and the public generally. There is no item that you could put in an immigration pamphlet, if you choose to do it, that would have a better effect on intending settlers than the fact that they would be secure in

obtaining the services of medical men well qualified because they had taken a license from this Board. (Loud applause).

Now, the Roddick bill aimed at a Dominion license. It certainly was an ideal bill. There was nothing that had such a tendency to Canadianize everybody than that bill. Unfortunately it did not go through. Some objections were urged by the people in Quebec and I believe that Ontario was not entirely willing. But, because that did not go through, are we to sit down and wait? Or shall we, as representatives of these new and growing provinces, make an effort to bring about something? Let us demonstrate to the people in the East that while we cannot at present attain to the ideal of Dr. Roddick we can get something approaching it."

Dr. Brett then went on to outline Dr. Roddick's bill and pointed out that it did not propose to take away the powers now vested in the different provinces of issuing their own licenses. "They would do just as they did to-day and the man who was not ambitious would take a license from the Province in which he intended to practice, while the ambitious man would take the Dominion examination.

Now, the scheme we proposed in Alberta was something like this. The four Provinces would unite on this basis. An executive would be appointed for all the different provinces; that executive would appoint examiners from the different provinces and those examiners would hold the examination. So far as Alberta and Saskatchewan are concerned, both were willing some time ago to forego any authority to issue licenses themselves. Personally, I would be in favor of all the provinces surrendering any rights to license. Let them do the teaching, but let the central examining body give the license. I have no doubt that if your province wished to retain the power to license, you would find the majority of your students would be ambitious enough to take the confederate examination.

There is a question that has been asked by two gentlemen here, and that is, "Have you got the power to do this? Has the Dominion government sanctioned it?" They have nothing what ever to do with it. You have the right in your province to do certain things with reference to medical education, such

as licensing members to practice. In Alberta we got in line years ago for the Roddick bill, and we have an amended act by which we are allowed to combine with any of the other provinces, and it only requires some slight amendments to the several acts of the province to enable three or four, or more provinces to come together and say that we will conduct our examinations, licensing of candidates, and so on, along certain lines. The government have nothing to do with that. Of course, they have the power of veto, but it is a power seldom exercised and certainly it would not be exercised against any amendments of that nature. The question as to where the examination would be held can be discussed and arranged satisfactorily. Probably three could be held simultaneously: one, say, in Regina, Winnipeg and Victoria, but that can be very easily arranged. The questions of money, fees, and so on, are only matters of detail and can be very easily settled.

One matter, however, would no doubt be a bone of contention, and that is as to whether this should be retro-active. This has been much discussed. So far as I am concerned, I think it would be just as well not to have it retroactive. In Alberta we are in a rather different position from the other provinces. We will say that you are probably aware that there are practicing here men who have not the necessary qualifications to go up for examination: who have never taken a degree, some from England or the United States, but who have been practicing for a number of years. So perchance a good reason why a clause in that new act should include all those in practice at that time, is because they have vested rights. That is something that is always regarded in any kind of legislation."

The Doctor then referred to conditions in British Columbia where, in some quarters, the idea of confederation was regarded with disapproval. He could understand why British Columbia or any other western province would not care to make a compact with the provinces of the East.

"In the West our interests, however, are almost identical. We have lands to settle. We are looking for increasing immigration. It will be difficult to say which of the three prov-

inces within the next twenty years is going to receive the greatest number of new settlers. It is not unreasonable to assume that there will be graduates from Manitoba, for instance, who will make their homes for practice in Ontario or any other eastern province, so that we would certainly be placed in a disadvantage in making a compact alone with one or two of those provinces. But, in the West, our interests are almost identical, and in fact, for the last ten years it would have been better for graduates of British Columbia to have had reciprocity with the other provinces of the West, because a greater number of people have come to each of those provinces than in British Columbia, so that it would have been a distinct advantage for them to have four provinces to practice in, and there is no reason why British Columbia should expect a greater influx in future than either of the other three provinces. Of course, we should not forget that anyone who is anxious to go to British Columbia has merely to pass their examination and then he can be admitted.

Among other advantages, you would have greater power with your several legislatures. No doubt you have had some experience in getting medical legislation. Probably it is less difficult now. It is less difficult every year, but for some years it was a very difficult matter in the Northwest Territories to maintain the integrity of any medical act very long. If these four provinces were confederated, a joint representation from the executive could speak with very much more authority—certainly they ought to command greater respect than one province speaking alone. If they were united on any question in connection with legislation, a legislation would hesitate before they would refuse to comply with any reasonable demand made by such an authoritative body.

Another advantage is that you would get earlier recognition by Great Britain. Dr. Brett then referred to the methods of organization. He was willing to make considerable sacrifices to bring about a better condition of affairs. There were a sufficient number present at that meeting to leaven the whole West if every man would become an active worker. Concluding, he thanked them for their attentive hearing and he would be glad to take back to his conferences in Alberta

the opinion of the profession in Winnipeg. (Applause).

Dr. Chown, in the discussion that ensued, said, "I am satisfied that the profession, not only in Winnipeg, but in Manitoba, have been practically unanimous for a long time in favor of any scheme that would throw open the portals of work for graduates throughout the Dominion in the widest way possible. It was a great disappointment to us that Dr. Roddick's bill did not go through, because the College of Physicians and Surgeons, our official representatives, had agreed to support that bill. I am satisfied that the College of Physicians and Surgeons to-day in Manitoba will back up any scheme that is feasible to unite the western provinces. Medicine is practically the same the world over. Perhaps the tropical climates need some special course, but in all temperate climates it is the same and it has always been to me a great source of regret and annoyance that each province should put up a strong wall around itself and say, "Thus far shalt thou come only." So far as I am concerned, I am heart-whole in advocacy of the scheme as proposed by Dr. Brett. If there are troubles to be faced, I think the only way is to get together and find out what they are and meet them as presented. The idea is a perfectly good one and we should be willing to spend time and effort in carrying it out.

As Dean of the Medical College, however, I would like to see something attached to the scheme which would admit of supervision of the course and supervisions of the examination of any teaching body in the four provinces by its central board, in such a way that it would not be necessary for any student coming from that university to take a second examination. I think that it is one of the gross outrages of the system of the past. A man gets his degree from a reputable institution and has to go before another board to get his license." After detailing the methods whereby examinations might be conducted, Dr. Chown concluded by stating that he felt very strongly the need for doing away with interprovincial boundaries. (Applause). He was not committing his college at all, but he personally was willing to join heartily in any feasible scheme for the federation of the four provinces.

Dr. Patterson said that his views on the subject were set

out in the Western Canada Medical Journal. He held very strongly with Dr. Chown.

Dr. Milroy said that he had listened with great pleasure to Dr. Brett's remarks. They had discussed the question between themselves in a limited way. It was a burning question and Dr. Brett's remarks threw a good deal of light on the subject and provided them with a good basis on which they could proceed to take steps to accomplish the object in view. As a member of the College of physicians and Surgeons he was in the same position as Dr. Patterson and had come merely to listen. There were breakers ahead but he did not think they were unsurmountable. Manitoba was at present in a different position from the other provinces, because the power of holding examination was vested in Manitoba University.

Dr. Chown here stated that the power was vested in the College of Physicians and Surgeons and although the University conducted the examinations, the College had the power to resume the function at any time.

Dr. Milroy said that he had interpreted the conditions differently. He was under the impression that this function had been surrendered to the University by legislation and that to revoke it would require a special amendment to the Act.

Some discussion then took place as to the question of several examinations. Dr. Chown said, "I believe these double examinations to be a curse to the medical profession of Canada. I think it a disgrace and a shame to have these provincial licensing boards. I say let the examining board give a degree and a license and let the board lay down the curriculum so that when our students are examined they shall have a degree and a license. I do not want to see any scheme put forward that will compel our students to take two examinations and if it comes to that, I will fight it from start to finish. I will beg the University to give up their examining powers to the central board and grant a degree in order to dispense with a double examination."

Drs. Hughes and Nichols coincided with this suggestion and Dr. Harry J. Watson also dwelt upon the advantages

which a central board might secure in the way of reciprocity with Great Britain. Dr. Hunter said that he was decidedly in favor of the scheme.

In closing the meeting, Dr. Todd said that the opinions were most encouraging and practically unanimous. Everyone seemed willing to give and take. It remained only to wipe out a few technical difficulties and if all the different factors in the movement were willing to approach it in a compromising spirit, there should be little difficulty in bringing the desired end about. A motion was thereupon put and carried to the effect that the chairman appoint a committee to formulate a resolution giving expression to the feeling of the meeting with regard to the question of western relations.

The meeting terminated with a hearty vote of thanks to Dr. Brett.

CLINICAL MEMORANDA

Case No. 1. Patient, Male, age 27. Had shoulder dislocated five years ago. Reduced at time but recurrence of dislocation occurred at different times thereafter, the rent in capsular ligament not having been repaired.

The last time of dislocation was in April 1906. It had not at this time been reduced. An attempt was made to reduce it under chloroform by two other surgeons the following March, but as expected, was unsuccessful. He came under my care last February and I undertook a cutting operation in March of this year, Drs. Ellis and Black assisting. Previous to operation he could abduct the arm to about an angle of 30 degrees from axilla—the head of humerus being dislocated forward under the coracoid process of scapula. He can now, 4 months after operation, raise the arm to beyond a right angle with the axilla and place it behind the head. The atrophied muscles have filled out considerably and it is still improving, and great gain in strength of muscles has followed.

The following plan of operating and fixation was pursued: An incision down over the centre of deltoid from acromion through skin and fascia was made, as in first step of Farry's amputation at shoulder; the flap dissected up and connected by a second incision below clavicle and parallel to clavicle, exposing well the head of humerus. The adhesions were then broken and divided as completely as possible; then reduction and dislocation by Kocher's method, the rent in ligament closed with twenty-day chronic gut, and the forearm brought well forward over chest, with hand over opposite clavicle, after suturing the skin incisions, and fixing firmly in position with adhesive and bandage, making outward and upward pressure of the head of humerus. Plaster of Paris bandages were then rolled around forearm just below the elbow passing upwards over the acromion process of scapula and down behind the starting point, making firm pressure of head of humerus in glenoid cavity, being the principle applied by Lorenz after reducing a congenital dislocation of hip. This latter means was adopted for the purpose of promoting absorption

of filled-in material in the glenoid. It was allowed to remain in this position for two weeks, the dressing being then removed, the stitches in skin of silk worm gut taken out, and fixed in same position as before, with the hand brought still further over opposite shoulder, the wrist resting on opposite clavicle. This position was maintained for two weeks longer, making four weeks in all. Then arm was placed in a sling and passive motion practiced daily during the following two weeks, when he returned to his work as a confectioner. Some passive motion has been intermittently practiced since then, and daily massage. The glenoid cavity was not curetted in this case as is advised by some recent writers, dependence for absorption being placed on the pressure applied.

Case No. 2. Male, age 45. Diagnosis—Tabes Dorsalis, (Locomotor ataxia).

Family history negative for paralytic or other nervous affections and syphilis as far as known.

Personal History—Never had syphillis nor any illness of importance except typhoid fever fourteen years ago, from which he fully recovered. Has had the Grippe but not laid up in bed with it. No bad habits; not alcoholic but very temperate.

He first noticed weakness in left leg and thigh about four months ago, which has increased since until quite marked at present. Inco-ordination is a very marked symptom in this case. Cannot stand with eyes closed nor touch points of forefingers, etc., and has diplopia on looking at a distance to the right. The left leg is paretic and the paresis is extending upwards to hip. Little finger in right hand is numb, having lost sensation in ulnar nerve. He had at the beginning of his illness some pricking sensations, as prick of pin in legs and thighs but no other pains and those he has not had during last two months. Has had lately, during past week, pains on flexor side of forearm near elbow at night when asleep if forearms are flexed. Has bladder symptoms; incontinence of urine when he desires to micturate. Left pupil is sluggish in reaction to light; no other pupilary symptoms. Patellar reflex rather exaggerated. It is usually weaker than normal or

lost, but may be exaggerated at first, becoming lost later in muscle atrophy. There is no anaesthesia in the limb most affected — no pain on pressure along the course of nerves anywhere. No ankle clonus (as in spastic paralysis), no appreciable loss of memory. The midthoracic girdle symptom of tabes and gastro-intestinal crises are wanting.

The treatment which is just begun is potassium iodide in increasing doses and mercury. Mechanical treatment is also directed, as stretching of the spine by having him sit on the floor with legs straight and bend head and shoulders down towards thighs, the attendant assisting by pressing on back of shoulders. This stretching plan will be carried out for two minute-applications twice a week. Some of the movements advised to improve co-ordination are also being practiced.

Case No. 3. Female, age 22. Nine months ago she noticed discoloration on arms, later on neck and some other locations, which was brown in color, giving a bronzed appearance as in Addison's disease of the suprarenal capsules. She has had loss of weight, about 10 lbs., and complains of malaise, —a tired feeling. Lately some light spots with loss of pigmentation, are appearing about margin of the brown pigmented areas, some of these in scalp with loss of color to hair in spots, as may occur in simple leucoderma. Since going to the country three weeks ago from which she has just returned, she has less of a tired feeling but no other improvement. Pulse and temperature are normal. Patient has rather frequent and weak pulse, and some diarrhoea of late. Only tubercular relation was mother's mother who died of consumption. She has always been a strong healthy girl with very little complaint of illness.

Examination of the urine shows some nephritis which might account for the tired feeling, and loss in weight.

The treatment begun is adrenalin sol. 1:1000 in 15 m. doses diluted and milk diet with some cream as advised by Von Noorden (Von Noorden's Diet for Nephritis).

Urinalysis in this case Sp. G. 1030. Albumen small amount; some granular casts and numerous epithelial cells; no pus.

Blood examination does not show patient to be anaemic.

Wm. Dow, M.D., Regina, Sask.

Case of Chloral Poisoning.

W. C. Ch., age 27, cook, intemperate.

March 22nd. Had supper about 5.00, and then went from one saloon to another drinking frequently and immoderately. Returned to his home before 8.00 p. m., became very melancholy and threatened to commit suicide. No attention was paid to him, so he took a box containing drs. 12 chloral, emptied it in some whisky and swallowed it when no one was looking. In a few minutes he fell, had a profuse epistaxis and became unconscious.

Arrived at 8.35 p. m. Patient profoundly comatose, intensely cyanotic. Radial pulse imperceptable. Heart is felt beating rapidly, 140. All muscles completely relaxed, eyes fixed, pupils dilated. Respiration about 38 sterturous. Strychnine nitrate gr. 3|40 Hypodermically. Stomach tube passed without the least resistance and stomach thoroughly flushed out. Atropine 1|50 Hypodermic and Amyl. Nitrate inhalations given. Hot water bottles to feet and sides.

9.20 p. m. Radial pulse returning 124 weak, irregular intermits every 2nd and 5th beat, pupils dilated, no reaction to light. Respiration 36 sterturous. Temperature 97.5. Cyanosis diminishing.

9.40 p. m. Face very pallid. Urinated involuntary.

10.00 p. m. Pupils very greatly dilated or contracted. Slight contraction when 16 c. p. electric bulb is brought close to eye. Tracheal rales, tongue must be brought forward frequently to prevent closure of Glottis.

11.00 p. m. Radial pulse more regular. Intermits about six times per minute, 120.

1.00 a. m. Improvement continues, has urinated involuntarily, still unconscious.

March 23rd, 8.00 a. m. Unconscious, but at times restless. Pulse 108, temperature 98.

5.00 p. m. Murmurs indistinctly, can be easily aroused and sometimes awakens for a moment. Later in his attempts to rise fell often and had many contusions on his head.

His progress afterwards was not worthy of note. Careful enquiry among independent witnesses proved that he had taken about 12 drs. and on his return to consciousness he confirmed

the statements which had been made while he was comatose. Recovery was probably due to the great dilution of gastric contents and slow absorption with alcohol.

E. Reavly, M.D., Rosthern, Sask.

Case of Spontaneous Amputation of the Appendix.

Thomas B., farm laborer, aged 40 years, Irish, a man of splendid physique and exceptionally good family history, admitted to the hospital at Yorkton July 1st, 1908, after an illness of four days suffering from appendicitis. Gave a history of a similar attack in November 1900 which laid him up two days. Kept at rest and under observation. Temperature, which never exceeded 102, steadily declined. Gradual disappearance of all symptoms including local pain and tenderness. Discharged convalescent July 8th with advice to return after a month for appendectomy.

He resumed his occupation and says he enjoyed good health until about 9 p. m. on Oct. 18th, when, while turning in bed, he "felt something give way inside" and was immediately seized with sharp pains in the right side which rapidly spread all over the abdomen. Was removed in a rig six miles to the hospital and operated at 11 a. m., on Oct. 19th. On opening the abdomen, an odorless purulent serum escaped and along with it two very small foecal masses. The appendix was found wrapped with inflamed omentum. There was no direct connection between it and the coecum and no opening in the coecum. The appendix was removed along with its wrapping of inflamed and adherent omentum, its mesentery being tied off. On longtitudinal section its lumen at the proximal end was obliterated for about one fourth of an inch. It was inflamed but otherwise apparently healthy.

With drainage and the Fowler position the patient made a somewhat stormy recovery and was discharged convalescent on Nov. 13th.

The peculiar feature of this case is that notwithstanding the comparative mildness of the second attack spontaneous amputation of the appendix had evidently occurred with the escape of a very limited quantity of foecal matter and a rapid closing of the coecal opening.

T. A. Patrick, M.D., Yorkton, Sask.

EXTRACT

"The Western Canada Medical Association is said by the Western Canada Medical Journal to be the great desire of those interested in medical progress in the West. This, of course, means a medical association formed from the members of the profession in Manitoba, Saskatchewan, Alberta and British Columbia. It is feared in some quarters that if such a society be inaugurated that it might be detrimental to the national medical body—the Canadian Medical Association —While at present the Canadian Medical Association is endeavoring to consolidate the medical profession of Canada and to have its various provincial societies affiliated with the parent body, there should be a united and earnest effort to accomplish that end and to do it effectually and quickly. The West like the extreme East—and there they have the Maritime Medical Association, in addition to their provincial medical societies—can scarcely expect to have a meeting of the Canadian Medical Association more often than every seven or eight years, though the ever increasing population and development of that great country may, in the near future, act more strongly as a determining cause for less space of time between meetings. In the meantime, if the West desired a medical society of their own to embrace the four provinces to come together in annual session, the inter-communication between its members would be sure to act rather to the good welfare of the National Medical body than otherwise. There are a great many who believe, in order to consolidate the medical profession of Canada, that an official journal is essential. Others have pointed out the difficulties and expense attached to such an undertaking. Some advocate a "Weekly," others a "Monthly," without probably giving due consideration as to where the money is to come from. No one has yet solved this difficulty. While it should seem fitting for a national medical body to have an official journal of its own, it must be remembered that we have but a limited

field in Canada, and that there are such necessary things as subscriptions to collect, advertisements to secure and printer's bills to pay. To float a "Weekly" Journal would require a large amount of financial aid none of us at present would care to think about. It is very doubtful if a "Monthly" would be in keeping with the dignity of a national medical body."—From Dominion Medical Journal, Feb., 1909.

The College of Physicians and Surgeons of Manitoba at their last meeting selected Drs. Patterson and Milroy as their representatives to confer with the Colleges of Physicians and Surgeons of the other Western Provinces and so try to bring about Reciprocity, thus following Dr. Kennedy's suggestion.

PROCEEDINGS OF THE WINNIPEG CLINICAL SOCIETY

The Winnipeg Clinical Society met Tuesday, Feb. 9th, with Dr. Hunter in the chair.

Dr. Rorke presented a boy, aged 6½ years, complaining of a lump on the left side. Child was partly breast-fed up to 2½ or 3 months of age, then entirely on the bottle. He remained well enough until he began to creep and support himself by holding on to what was near. At this age he fell on a dumbbell, injuring his spine. About twenty-four hours later he wakened up in the night with a cry and seemed in pain. Was ill for two or three months when a small mass was noticed on the spinal column in the dorsal region. He wore a steel support for about 7 months, then a plaster jacket for 8 months. The steel support was worn again until one year ago. Otherwise history is uneventful, until the lump on the left side between the crest of the left ilium and the 12th rib developed in February or March, 1908. I should say, the last rib I could find, because in some of these cases the floating ribs are not well developed.

Family history—Great grandfather had a similar condition with the spinal column following a fall from a wagon, although he lived to be a good old age.

The father's mother died at the age of 34 years from some sort of fever—not following parturition. Father is living and well, also mother. One of mother's brothers suffered from broken-down gland in the neck, resulting in a sinus. Sister of patient is healthy. The little fellow is 38 inches, the average for a child of his age is 44.1 inches. Has good color and is active. Could find nothing in the analysis or urine. Urine is light straw colored, 1010. specific gravity acid; no albumen; no sugar.

The lump is about the size of a small hen's egg. It can be reduced. I thought I got a little gurgle when it is pressed back. It is located in that region which is left as a triangular space, where the left Latissimus Dorsi is fastened to the crest of the ilium, forming the posterior boundary and the external oblique forms the anterior border. I think there is a portion of the bowel projecting through it. I know there is the possibility of a cold abcess there, and I suppose one might think of the fatty tumor. I scarcely think that a cold abcess would go on for a year without giving some evidence of breaking down. There is no evidence of breaking down. I think there would be a discharging sinus by this time. This has been since February or March, 1908. The deformed spine came on when the child was about 13 months. The small lump has come on only during the last 18 months. No temperature. Has had some pain in the abdomen and that is the reason they have asked me to see him.

Dr. McKenty—I think it lies between a psoas abcess and a hernia. I think it is a hernia. The protuberance is too flaccid to be a psoas abcess. Also, there is some impulses on coughing; there is an increase in tension in the tumor, however, that would exist in either, and on ausculatory percussions there is perhaps not as great an exaggeration of the sound upon percussing over the stomach as there is on percussing the points equally distant from the protuberance—from the hernia, if we may call it such—I think the auscultatory percussion yields a lighter note when it is made over the region of the stomach

than when made over the region where the psoas abcess would be likely to start. Then there is another reason, there is a distinct ring to be felt and the lower margin shows a pediculated body, which might be a portion of adherent omentum, or a calcareious mass, or it might be a mass of cheesy material from the psoas abcess and then when the child lies down the protuberance recedes very considerably in the direction rather outwards and upwards towards the spine than forward. These reasons are not conclusive, and a diagnosis cannot be positively made, in my opinion.

Dr. Lehmann—I am in the same position as Dr. McKenty. I do not pretend to make a diagnosis definitely, but there is this difference between us: He inclines towards a hernia and I incline toward a psoas abcess. Most of the systoms given can be utilized for both diagnoses, but the recession upon lying down can be explained by the supposed pus receding into a larger cavity. The impulse on coughing could result from a collection of pus in the abdomen as it would if it were a hernia. The same expansion would apply to both conditions as far as the lying down is conerned. If there is a larger cavity it would certainly disappear and to my mind in the way it does. The opening is very large and as I have happened to have had the advantage over Dr. McKenty of seeing this patient some time ago, and seeing positively that there was not an opening, or at least no protrusion at that time, and as it would be rather difficult to explain why such a large opening would appear in so short a time, I think the tendency is towards a psoas abcess. Then the explanation that could fit into that being a psoas abcess. Concerning the protuberance that is distinctly felt I think one might suppose that to be a more dense fibre of tissue which has not come away. For instance: the muscle has come away and this piece of fascia has not. I do not pretend to make a diagnosis and I think, that as Dr. McKenty does, that with one examination it is impossible to make a diagnosis. I am prepared to admit it may be a hernia, but as much as Dr. McKenty inclines to the one, I incline to the other.

Dr. Dorman—Which of the two conditions are most likely to occur in a case of this kind? I think the preponderance would be in favor of an abcess. I think you would get the abcess more often in this kind of cases.

Dr. Kenny—This condition has existed for a year, and it is very unlikely that the abcess would not have increased during the year.

Dr. Lehmann.—It is more than a year since I saw the child and at that time there is no appearance of anything. The percussion note, I think, is more duil than you would find with a hernia. That is open to many fallacies and I think one can get a wave through to the abdomen into the tumor. That is rather difficult to be positive about, either.

Dr. MacKay—I am inclined to agree with Dr. Lehmann as far as one can make a diagnosis of psoas abcess rather than for a hernia through the triangle of Petit. If the X-Rays were used, if it is a hernia I do not think a shadow will be given, and if it is an abcess the pus will give a shadow.

Dr. Kenny.—Wouldn't it be possible to give bismuth in this case and locate the intestines?

Dr. Fletcher.—Would translumination of the tumor, with a transluminator with a hood around it, locate the pus in it by the shadow?

Dr. Lehmann.—I think Dr. Fletcher's suggestion is one fully worth trying.

Dr. Rorke.—On account of this child having Pott's disease at such a young age it will give rise to disproportion in its two circulatory systems, and before that child is 25 years old, there is a liability of him dying of heart trouble and not of anything else.

Dr. McKenty presented a case of Renal Calculus with interesting points of diagnosis. The patient a young man, a laborer, aged 18, family history bad, both parents died of Tuberculosis. Admitted into St. Boniface Hospital, Nov. 1908, and gave the following history a gradual onset, 2 years ago, of pain over the caecum, being the most prominent system, their was no frequency of micturition, retraction of the testicle, nor pain in the back. His physician removed his appendix and he was relieved of his pain for two months, but on returning to work, the pain returned and has been gradually getting more severe ever since. Had been unable to work for some months. At present slight frequency of micturition, and once or twice nightly.

Examination elicited tenderness an inch above and to the inner side of McBurney's point and at this point a tender nodule could be felt, which suggested stone in the ureter. The kidney itself was not tender on pressing, either anteriorly or postriorly. The pain was always present subject to marked exacerbations, which were sometimes accompanied by chills and vomiting, but never frequency of micturition.

While in the hospital 12 to 15 examinations of the urine was made, pus cells and a few red blood corpuscles were always present, during an exacerbation these elements were increased and on one occasion the reaction was alkaline, and there was a deposit of phosphates, reaction other times acid. Several 24 hours specimens were examined for tubercular bacilli with negative results. Cystoscopic examination showed a perfect bladder, except that the right ureter orifice was swollen and protuberant, while the left presented the normal slit-like opening. Jets of clear urine spurted from each, but that from the right was more voluminous and projected farther and was also directed more transversely across the trigone than that from the left. Here was a distinct difference from which, according to Mr. Hurry Fenwick, we may safely infer that from some cause the right kidney was doing an abnormal amount of work, and that its pelvis was to some degree dilated. Such cause might be the presence of a stone in the pelvis or the ureter. It was determined to explore the presence of a tender nodule in the course of the ureter, and the fact that a ureterin stone may be tunnelled or sacculated, so as not to obstruct the urinary flow—though such is undoubtedly rare—led me to explore the ureter first. This was done extra-peritonially through a muscle-splitting opening. Four to five inches of the ureter even thus readily exposed to visual examination, as it was raised up with the peritoneum of the posterior abdominal wall to which it is closely attached. It appeared quite normal and the wound was closed. The kidney was then exposed through an obliqueloin incision and as it was situated uuusually high, subperi toneal resection of a part of the twelfth rib was done to gain more room.

The stone which you have seen was removed from its lower by an incision a little below the middle of its convex border—the least vascular area of the kidney. His convalescence was normal. In the early history of this case, it is interesting to note the absence of definite kidney symptoms. His physician states that the appendix was normal to macroscopic examination, so we are justified in referring that the stone, not the appendix, was at that time the source of pain. Nothing less than several microscopic examinations of the urine would have availed in making a correct diagnosis. An X-Ray examination was made with negative results.

Dr. Bond, Case 1, Male 23.—The history of this case is that some 8 or 9 years ago during the last year at school he began to have some little jerkings or twitchings of the muscles of the neck and shoulder. At the time he had been suffering from headaches and was given glasses for astigmatism, which didn't relieve very much. Later glasses were applied for short sightedness, but didn't make much difference to the jerking which gradually increased and became rather severe and involved the head in a rotating movement from side to side, and the shoulders, causing them to shrug, and the legs, especially the left foot, causing it to jerk when walking. The movement of the head is at the present time sufficient to make him conspicuous among people and worries him, although he is a man of sufficient will power and intelligence to understand that a thing of this kind shouldn't cause any worry. When about 8 years old he fell over the banister, from one floor to the other, in a hotel and lit on the shoulder. Nothing followed that. The family history is good. The life history is good. Nothing detrimental in any system in the body, beyond the event of this twitching, which he can sometimes control by will power. Sleep is good. It neither interferes with sleep, nor prevents him from going to sleep. This is sometimes a troublesome feature in these cases. There is a slight want of tone in the left knee jerk, but I don't know that it signifies much. The control over the spasms is very good tonight. The movement seems to be bilateral, more marked on the left side. The muscles involved are the deltory and the sternocleidomastoid and the trapezius. There is a slight jerk of the foot, which occasionally causes him to stumble. The face muscles twitch a little, but it is the result of the sternocleidomastoid movements. There is nothing that can throw any light on the disease except the accident, and it is a long time between the eight years of age, when the accident happened, and the age of his leaving school at 13 years. Recently he thinks he has got a certain amount of control and he doesn't have the same amount of twitching or jerking when sitting quietly, as he used to have.

Paramyoclonus multiplex is apparently a disturbance of the central control of the muscle movements. It is a motor neurosis, and consists of violent shock-like contractions of the muscles in various parts of the body. The contractions may be so slight as to be fibrillary and scarcely visible, or they may be violent as to throw the patient down. It doesn't affect muscles, which are controlled by any one particular nerve supply. There is no co-ordination, muscle or number of muscles may be affected. The will cannot produce the effects that are seen in these patients in the number of muscles moved at the same time. The spasms or contractions may be symmetrical and are generally so, and may be isochronous—that is, both sides moving at the same time—although that isn't always shown. The parts of the body most affected are the limbs, then the muscles of the trunk and then the muscles of the neck and face. The upper limbs are more often affected than the lower, and the proximal muscles are more commonly involved than the distal. In the upper limb the deltoid and the pectoral muscles; in the thigh the quadriceps extensor muscles; and in the trunk the recti, the obliques and the erectores spinae are most ofter involved. The diaphragm and cremasters may be involved. The will has distinct control over the motions in many cases, and any voluntary moement will stop, in some cases, the spasmodic contractions that occur. The contractions cease, as a rule, during sleep, although this isn't always the case. I have seen cases where this has been a great cause of sleeplessness. The disease is not uncommonly associated with epilepsy. That appears to be the only other disease which is as-

sociated at all in any systematic manner. There is no known cause of the trouble. Heredity seems to have no influence. Patients suffering from neurotic troubles are most liable to be affected with this disease. Of the immediate causes, prolonged mental or physical exhaustion, the mental strain of long attention to studies or business seem to predispose. Speech may be a little interfered on account of the muscles which control it being involved.

The sensory phenomena are not affected beyond a slight sense of fatigue. The knee jerks are sometimes affected ,sometimes not. Psychic disturbances are not, as a rule, present, although the memory and attention may be impaired. There is a little coldness of the extremities, and sometimes profuse sweating, otherwise there is no other trouble to be found. That, as far as I can gather it, is the classical history that the disease ought to conform to, but it doesn't always conform to it. I have here the history of several cases which I have treated, and shall read you a short outline of them.

There is no pathology, and no one knows anything about it. The treatment is very difficult.

Dr. Bond reported five other cases. All of them have responded splendidly to electric treatment.

Dr. Kenny.—How does it differ from chorea?

Dr. Bond—Chorea involves muscles which the will can control. Usually involves the face muscles. As a rule an attempt at voluntary movement will set up an attack in chorea, and not control it as is the case in paramyoclonus. The movements in Chorea are generally unilateral.

Dr. Hunter—For paramyoclonus multiplex he has got extraordinarily good results, because it isn't a conditions that yields well to any form of treatment and the question of hysteria has to be seriously weighed. Chorea can be ruled out in all these cases for the reason he assigned, but hysteria I don't think can in some of them at any rate. The boy there, I suppose it, cannot be any form of habit spasm. The diagnosis in these cases are correct. While some cases are recorded as absolutely cured, I think it would be unusual to have four cases respond to treatment.

Dr. Sharpe—Isn't it true that in a case of paramyoclonus multiplex you have muscles with their origin in the trunk and their insertion in the extremities affected and these are affected bilaterally always. I saw a case this morning in which that diagnosis was made and a slight tap on the tendons caused a tonic and clonic convulsion, almost a tetanic convulsion and these occur bilaterally and there is a contraction of the muscles, which have their origin close to the pelvis and the flexion of the limbs.

Dr. Hunter—As to reflexes, one may have normal, increased, or rather diminished reflexes. As to the face muscles it was described in one case only, the face muscles were not affected, but other cases have been recorded since and in half the cases the face muscles are affected. The whole difficulty has arisen that Friedrich described the affection on one particular case, and he described that patient as getting better and subsequently three was a relapse.

Dr. Sharpe, Case No. 1.—This case is attending the outdoor department of the W. G. H., and having had a case of a similar nature exhibited at the last meeting I thought this would be interesting.

This man is 24, born in Russia. Admitted to hospital April 23, discharged May 30. Pain and swelling in right superior maxilla. Mother died at 48, heart trouble, father alive and well at 58 Two sisters living and well. He was never ill in his life before. In November, 1907,

had five teeth withdrawn; no trouble afterwards until about two weeks. Discovery of real trouble dates back to trouble from pulling teeth. After they were pulled he couldn't sleep for months, a piece of the root was left in with the jaw. A specimen sent to the pathological department report camaveno caroma.

Dr. Lehmann.—I saw this case last summer and at that time the diagnosis wasn't very clear. The enlargement has diminished since and the spasm of the jaw has materially decreased and his condition is better than eight months ago. He has still the dilation of the pupils, which he had then which we considered could be explained by some cerebal secondaries, but apparently that is not true. An operation was advised against, because if it was malignant it was hopeless. Pieces of bone have come away and the symptoms came on after teeth extraction and so osteomyelitis has to be considered. Iodid was given after operation was advised against, the symptoms alleviated, but not quickly enough to make a diagnosis of syphilis.

Dr. Raymond Brown—Pot. Iodide should be pushed to the limit. Perhaps the reason he didn't clean up on this was on account of the osteomylitis.

Dr. Dorman.—I saw a case in the Old Country and the microscopic diagnosis showed it a malignant trouble. He was attending the Throat Hospital and they put him on iodide of pot. and they pushed it to the extreme and the man cleaned up almost entirely in six weeks. It was a very similar case to this one, but a more blocking of the nose.

Dr. Elkin.—This is a young man, bookkeeper, aged 26, single, good history. In 1906 he developed a little boil in his neck. He had good health until he had typhoid fever a year afterwards, which laid him up two or three months. The present illness dates from August 10th, last yaer, when he went to Winnipeg Beach. He ran to the station, getting warm and had the draught blowing on his face from the open window. A week or so later he complained of pain in the face and sore throat. On the 9th day some ashes from a cigarette got into his eye and burned it, and two days later he had complete facial paralysis. I gave him some general treatment. Put him on pot. iodid; very little result. Also gave applications of faradic current in the nature of massage, six or eight treatments. Treatment gave slow results, and he fell into other hands and he has had almost daily applications of treatment from the end of November until now. Though a right side paralysis it now seems to be on the left side, because there is a certain amount of contraction and the nasal labial fold is much more marked on the right side and the mouth is drawn to the side that is affected, but on asking him to smile, you will see that the other side is the well side. The symptom which troubles him is epiphora. He notices it most when eating, the action of the jaw removing the puncta. He has lightning-like contractions occuring at irregular intervals, also a tightness on using the electrical treatment and he would like to know if he should continue with the electrical treatment or no.t It is now 5½ months since it happened, and you will notice sometimes the right lid will not close when the other will. No paralysis of the soft palate, no other muscles involved. Occasionally the eye trouble disappears and then comes back again.

Dr. Hunter.—In London they advised against electrical treatment. They advised soft massage and inserting some body inside the mouth to stretch that side of the face. The matter of epiphora is also mentioned, but there is no reason mentioned why.

Dr. Raymond Brown.—This man is 64, carpenter, been well and active up to 6 months ago, when he had considerable stomach trouble, acid, he said, coming up into his throat, and he couldn't eat. About two months before the stomach trouble he began to notice some obstruction in the nose, difficulty in breathing through the nose. Four months prior he went to see a doctor because he had a swelling over the side of the face, had both eyelids shut and had an abcess of the lacrymal sac. The doctor, in order to relieve the abcess, pulled the only three teeth he had on this side, and he apparently got well in a month. At that time the eye had swollen shut on that side and has been ever since. He has been miserable, first, because he has no teeth to chew his food with, and second, because he cannot eat all kinds of food. On examining the nose I found a large cauliflower-looking growth. It was more solid and corrugated than a polypus. The hemorrhage is very severe. I slipped a snare noose around it and took a piece out of the tumor. None of the hemorrhage goes into his throat on that side. The illuminator doesn't show anything in the antrum, although from the way he described it at first I thought this might have begun in the antrum. The section of the tumor is under the miscroscope and I brought him here tonight because I want to elicit some discussion as to treatment. He has lost fifteen pounds he says, and his son says he has lost nearer thirty pounds. He weighed 160 six months ago. This has lasted nine months since he first noticed the nasal obstruction and six months since he had any swelling on the face. Nothing in the mouth. No history of specific disease. When his stomach is sour he gets what he calls "weak heart."

Dr. Lehmann.—I think the only imperative procedure that would help this is to turn back the nasal flap and go at it from the outside and remove whatever is diseased and be prepared to go as far as you like, or as you needed to. I would advise an operation. I cannot see any secondary involvements. I don't think the stomach trouble can be associated with the tumor in his nose, and I really don't see any contra indication for doing a radical operation. Of course we know that malignant growths originating from the nasal surfaces are very malignant and are apt to recur. The man hasn't any chance without an operation, and while the chances with it isn't very sure, still I think it is better than without.

Dr. G. W. Fletcher.—It is hard to say how far these growths extend internally. I think it would be difficult to remove the whole growth. He also shows some glandular involvement. I think I would be inclined to let it go the way it is, with palliative treatment.

Dr. Brown.—In my own opinion, if I can get the patient's consent, if I find no contra indication in the urine I think that with his permission we will resect practically half the upper jaw and be prepared to work in from the middle line outward, and take it all in to where the tumor extends.

The Winnipeg Clinical Society met Tuesday, February 23, with the president, Dr. Nichols, in the chair. In the absence of the secretary, Dr. G. O. Hughes read the minutes of the previous meeting.

Dr. Young showed a girl, aged 6 months, with asymmetry and deformed feet. The feet are bent in and there is a constriction in the lower part of right leg. The toe are deficient, the first two toes on the left side, and only four present on the right, although there is a

rudiment of the fifth one. Besides that there is an asymmetry of the face, the right side is smaller than the left, and the right eye smaller than the left—the palpebral fissure—and it doesn't close quite so well. During sleep the parents say it is always partly open. The action of the muscles on both sides seem to be fairly good. The confinement was quite normal. The other children are quite healthy, except for some signs of rickets, and one or two of the children were rather small at birth. Both arms and hands have free motion, and are perfectly formed and the muscles of the legs seem to be very healthy, no paralysis and no atrophy. This combination of signs would lead one to decide this is simply a case of congenital asymmetry, the possibility of intra-uterine affection of the cerebrum might be considered, but I don't think there is any proof of it at present.

Dr. Galloway.—From a hurried examination the deformity present in the feet is an ordinary talipes equinovarus congenital, of mild type. The associated absence of the toes is merely maldevelopment. The present treatment is ideal, simply manipulation of the feet. I refuse absolutely to undertake anything in the line of surgical treatment until the child is 12 or 14 months of age. I have tried both methods independently, and my mind is made up for all time that far better results can be obtained with far less danger to the child, without any interference other than the manipulations the mother can carry out until the child is 12 or 14 months of age. The condition of the face is an interesting one. In these cases of hemiatrophy or hemihypertrophy I am in doubt whether it is hemiatrophy or hemihypertrophy. In this case there is an atrophy of the face and the interest will centre in the future development of the face. As to the lower extremities I have seen at fourteen months of age a condition of the feet that was simply horrible, the foot like a child of eight years and in which amputation had to take place. From looking at this case, as it is, my impression is that while the two sides of the face are never likely to be symmetrical, I would hold out the opinion that probably relatively they will remain about as they are at present.

Dr. Lehmann.—I quite agree with what Dr. Galloway has said. I think the face, although of course one cannot be sure, will probably develop much in the normal way and although probably one side may remain a little larger than the other, I don't think the probabilities are it will amount to very much. One sees these slight differences in the face very frequently, and although this may be more marked than usual, I think there is nothing very alarming about it.

Dr. Nichols.—Would you consider hemiatrophy or hemihypertrophy are more marked in these cases?

Dr. Lehmann.—I have never seen a very marked hemiatrophy or melhypertrophy, except in the upper extremeties, The hemihypertrophy of the extremeties is very well known, but do not know of the face being reported. It sometimes extends to the trunk, more in the lower extremeties than in the upper extremeties, although it is recorded in the upper extremities; there is also asymmetry of the body, although of the face asymmetry there are not very many marked cases that have been recorded.

Dr. Hutchinson.—I just noticed a remark of Dr. Lehmann as to the cause of the toes being absent. I had a case of a child born, one foot was perfectly normal and the other foot had toes taken off, the whole foot was half an inch narrower than the sound one, and I don't think that that can be due to the amniotic bands; I think instead of amniotic bands this is a non-development. I had another case where

the child's left hand had no fingers, the right hand was normal and the child normal in every way. The first phalanx of the thumb was present, and then there were just beads where the other fingers should be. I think as far as the facial asymmetry is concerned, the tendency is for the two sides to get more alike as the child gets older.

Dr. Sharpe.—The right foot of the child was turned in very much more markedly than it is at present. Is it possible by carrying out these manipulations to in any way injure the muscles and cause an atrophic condition to develop?

Dr. Lehmann.—I don't think there is any danger at all unless it is done somewhat brutally, but in many cases the deformity can be overcome and in any event the correction is made much easier afterwards.

Dr. Sharps.—If one instructs the mother to manipulate the feet two or three times each day, is there any advantage in using a side splint in keeping it straightened, or would you postpone that until the child is older?

Dr. Lehmann.—I would postpone it until the walking age is reached. That the correction afterwards is so complete that it is not necessary to trouble the child or the parents.

Dr. Tees.—I would ask Dr. Young if he thinks there is any difference in the size in the temple region.

Dr. Young.—I couldn't make out any difference. The general contour of the heads of the other children, too, lead one to suppose that is natural the apparent behind and apparent narrowness here. I couldn't make out anythig beyond the general facial deficiency.

Dr. Johnson.—Can any one explain the contriction of the leg?

Dr. Young.—The constriction of the leg, I think, might be explained by the deformity at birth. There was no doubt intrauterine bending, and it had no doubt been present from an early period of gestation, and the skin was slightly constricted.

Dr. Brown.—This is a case of double cataract. I did iridectomy 7 days ago. Soft contracts.

Vision is reduced on bright days when his vision is small to something like 10-200ths. In about 10 days I shall do iridectomy in the other eye. Vision is nearly twice as good in the eye we did the iridectomy in. When the iridectomy in both eyes is performed, I shall get vision about average. No cataracts in the family, no convulsions, urine negative, comes from Isle of Jersey.

Dr. Johnson.—I presented a case being introduced by Dr. Galloway, who operated February 5th. This young man cut himself on the inside of the thumb early in November. A very small cut and he paid no attention to it at the time, and came under my observation a month later, noticing he had lost the control of the distal phalanx of the thumb, the long flexor tendon having been cut. He then began to notice there was a contraction of the next phalanx of the thumb, and he. couldn't. extend so well,. so he decided. he would have something done to it. The cut was just across the large part of the thumb in a slanting direction, and was made while opening a can of sardines.

Dr. Galloway.—I haven't seen this except eight days following the operation. The interest in the case lies in the extraordinary condition discovered at the time of the operation. The scar was very small, and the fact that he couldn't bend the thumb, the long flexor tendon being cut. We split the thumb down, expecting to find the ends of the tendon. The distal end was found in its usual position, about three-quarters of an inch in length. A search was instituted for the distal

portion of the tendon, it couldn't be discovered, and we made a thorough search for it between the small muscles of the thumb, but couldn't find any trace of it.

Almost in despair I cut down on the wrist and there discovered the tendon quite readily. It had been drawn up into the wrist and about four and a half inches from the end of this proximal fragment, and it was kinked and extending from this kink down into the sheaths of the muscle and pretty well down into the phalanx was a fibrous tissus and apparently an attempt on the part of Nature to establish a new tendon. The extraordinary thing to me was the amount of seperation, fully four inches, I think, occuring from a simple tenotomy of that tendon, done involuntarily. After getting the end it was a very simple matter to pass a suture through the tendon and draw the parts down. The two ends were separated even under strong traction and after putting the thumb into the most favorable position they were separated by an inch. The end of the tendon was split about an inch and a quarter from the end, and turned down and the two united with silk. It is too early to judge of the final outcome of it. I think there will be practically complete recovery of function. There is loss of sensation of the distal end of the thumb. It is of interest as to how best to deal with an injury of that kind immediately after the accident, should one see it. One would naturally expect I think to find the ends of the tendons near each other at the time of the accident, and the proper thing would be to repair if one suspected such an injury, but it goes to show that when one undertakes to perform an operation of that kind, even immediately after the accident, one should be prepared to do an extensive operation.

Dr. Watson.—If the repair had been done at the time of the accident, would there have been such a degree of separation?

Dr. Galloway—My opinion is that at the moment that was severed there was a tremendous spasmodic contraction of the muscular portion, the muscle from which the tendon arises, and it simply jerked it up into the wrist. The thumb is now more useful than it was before, and it was only operated on the fifth of the month.

Dr. Lehmann.—It is an extraordinary condition of affairs that the muscles, which have ordinarily such a little scope of contraction, should draw up to such an extent. If one looks at the small exertion of normal motion and then flies up six inches I think there must be an extraordinary explanation for it. Analogous cases are those tenotimes where there is no union. I think this quite interesting about the new fibre being formed in Nature trying to send forth a new tendon more frequently in the cases when the tendon sheath has not been injured. Should the tendon sheath have been injured, I presume there would have been no attempt at all to form a new tendon.

Dr. Nicholls.—This patient was using his hands, and this tendon wouldn't be lying in its sheath, it would be free, and would be propelled along through his catching hold of objects.

Dr. Galloway.—Your remark has suggested to my thought a further theory in regard to it. I think it is very reasonable and probable even that in an attempt being made the psychical effort to flex that thumb afterwards as we would do, the belly of the muscles would contract as one willed to make that movement, but the mechanical action would be impossible.

This patient came in to see me about a month ago complaining of great weakness and vomiting, and inability to go about hard work or to take food. She was considerably blanched and appearances in-

dicated nothing else than some digestive trouble, or anaemia. The teeth were bad and she wasn't able to chew her food very well. On examination she wasn't so thin as she is now, and there wasn't such ease of examination. But there is evidence of some enteroptosis, but her vagina indicated no abnormal condition. I sent her to the hospital and she made considerable improvement with dieting, and more with the care than anything else. The stomach showed sufficient of hydrochloric acid, the blood showed decrease of the hemoglobin and slight leucocysosis. This improved very much during the time she was in the hospital two or three weeks. She left, had a set of false teeth made and improved slowly in general condition. She later lost considerable flesh. I was called two or three months later, she was again suffering from the pain severe in abdomen and vomiting. She had some diarrhoea the time I first saw her, and was considerably thinner. I then had some strapping placed as low as her pelvis, but it was too uncomfortable and she couldn't keep it on, and care and diet was advised, frequent feeding in small quantities, and as fine as possible. Proteid rather than thyrocarbon. The medication was directed toward the constipation and the blood condition. I was called a month or two later and found that there was a tumor condition here, which puzzled me. The colon was much contracted and could be felt up the left side and across toward the stomach. The enteroptosis, the stomach seemed to be very much more fallen down, and the muscles quite weak. I inflated the stomach and found it was lying in the middle line and bulging out and down to three finger-breadth below the umbilicus and following up in a U-shape. The tumor still shows and occupies a position of a prolapsed liver, although a prolapsed liver never occurred to me at the time. She is very anxious to continue work and willing to do everything possible. Her father died of carcinoma of the stomach. By placing one hand well underneath between the ribs and the ilium and pressing up well you can find between the two hands a tumor about the situation of the kidney. By percussion you get the resonance. In the stomach contents there is a marked amount of mucus. She has been eating biscuit and some preserved strawberries. There are no very coarse particles, a little milk taken has curdled and shows in the contents. The stomach empties itself quite well. There is no growth at the pylorus which would stop the passage of the food. This shows no free hydrochloric acid and litmus paper shows no other acid. The treatment is propose to carry on is the washing out of the stomach and use of Carlsbad about twice a day with probably some hydrochloric with meals. I think douching and support would be very useful, but she ought to be in the hospital for that. The changes from time to time in her condition increased distress and increase of the trouble generally. You can feel the notch in the liver; it is like a spleen displaced. Menstruation stopped two years ago; she is now 34 years of age. This has been a long-standing case, of over two years, and no other signs of carcinoma. And the loss of flesh could be put down to poor nutrition.

Dr. Richardson.—Would a plaster of Paris bandage be of any use in this case?

Dr. McKenty.—I haven't used a plaster of Paris bandage in a case of pendulous adbomen. I have prescribed an abdomenal supporter with poor success. At the examination I don't think it could be classed as enteroptosis. The pelvic viscera are not prolapsed, enteroptosis refers to general prolapse of the pelvic viscera; I don't know what the condition of her abdomenal muscles are. It is the important point as to the prognosis, as to whether they are capable of being toned

up and can be got to act, the prognosis is pretty good under palliative treatment, but without these the only chances for improvement is operative. There is an operation performed for shortening the coronary and the lateral portion of the coronary ligaments also stitching up the omentum forming a hammock for the liver, stitching it to the abdominal wall.

Dr. Rorke—According to some of Keith's ideas of visceroptosis he makes a distinction between the organs above the umbilicus and those below. You may have considerable optosis of the organ above the umbilicus and very little below the umbilicus. As to the treatment the cause is not well enough known yet that we can say very much about it. Many claim the whole condition is congenital being found in the infant previous to birth. If that is the condition, I doubt if any treatment would be much more than palliative. If we distinguish between cases that are congenital and acquired, in acquired cases probably we could do something, but not in the congenital cases. Keith lays a great deal of stress on the abdominal muscles and he doesn't think the ligaments have much importance in keeping the organs in place.

Dr. Lehmann.—As to treatment I don't think that in this case any operation would have any particular benefit. An operation that might possibly come into consideration would be gastroenterotomy, with a view to allowing the stomach to empty itself, but I don't think very much would be gained. The stomach is distended below the umbilicus and the food instead of having an easy acess to the pylorus has to travel up against gravity and it doesn't consequently empty itself as well as it might otherwise. If the patient rested in the horizontal position after the meal, this gives the stomach the advantage of gravity. In these cases a thoroughly well-fitting abdominal support might help her, and then she has to consider the loss of use of the muscles and consequently greater weakening still. If the woman could have proper exercise, I think it would help her more than anything else, and proper dieting. I think there is a stagnation; the stomach does not empty itself.

Dr. McKenty.—The pylorus, more particularly than the fundus, is prolapsed in a case of this kind where the liver is also prolapsed. The organs prolapsed here are the stomach and liver, the fundic end of the stomach is attached to the esophageal opening of the stomach. The stomach, it is said, has difficulty in emptying itself, but this point is debateable, and I feel sure the difficulty isn't due to the stomach having to pump uphill, that is, the pylorus remains a permanent fixture, while the pit of the stomach sinks lower. As a matter of fact the pylorus is very much more moveable. The pylorus and the duodenum are attached to the liver by the omentum.

Dr. Lehmann.—The fact remains that persons with a distended stomach have a better digestion if they rest an hour in a horizontal position after eating, and that is a fact that cannot be disputed and can be most easily explained by food having to descend against gravity.

Dr. McKenty.—The question I wish to criticize is the indication that the pylorus remains in this position when there is a prolapse of the liver and these other organs, and I contend that is not the case. If there is a delay in the stomach emptying itself, it is not due to that fact, but due to loss of tonicity of the muscles of the stomach, and not to its position.

Dr. Gardner.—This man is 43 years of age, machinist, always been healthy until last year and a half; no serious illness! no specific history, and no alcoholic symptoms. History: the left arm gets tired,

much more tired than the right one. This has increased. No sensory symptoms, touch and pain and reflexes are normal, the grip is good in the left hand; has difficulty in buttoning his coat. This is extending to the left leg. I have brought him up for diagnosis. A little tremor in the left hand, between the thumb and fingers, somewhat continuous tremor. No atrophy.

Dr. Rorke.—I examined this case in a superficial manner. I cannot find anything the matter with the action of the eyes to the light or accommodation. There is some difficulty in the strength of the right and left side. The reflexes are present in knee jerks and tendon Achilles. I didn't get any information of Babinski, no particular reaction to it. The sensation on one side for heat and cold was there, and the ordinary sensation for touch and pain through the condition of the right side is more marked on the one side than the other. He does a fairly good day's work at a machine, but it tires him a great deal. I don't know that I can offer much information. There are cases of that kind of spinal atrophy of a chronic type, although there isn't an atrophy in his case, but this does not correspond to that which I saw.

Dr. Gardner.—It seems to follow the symptoms of paralysis agitans.

This patient, 55 years old, 5 feet 6 inches, weight 172, former weight 4 years ago, 230. Nothing of particular interest in history other than that referring to the urinary system; urine 10-26, slight amount of albumen; there should be sugar present. Test diet was meat, broths made from both beef or veal and made by expression, and began 10 ounces of olive oil, vegetables, cabbages, etc., and 7 ounces potatoes, peas, beans and turnips, not allowed. Milk, three pints, eggs 2, and rolls 2. I allowed him that diet for three days, and then took total quantity of urine which was 7 pints, and a urinalysis made of that showed no change in the percentage of sugar present. February 18, still continuing that diet probably a week after the commencement of the treatment, the percentage had reduced to 3.2 per cent. Six weeks ago he had been out for a stroll and on returning home his feet were somewhat cold and he took his shoes off and stuck his feet in a steam coil and was very comfortable and didn't notice any detrimental effect for some time, but a few days afterwards he noticed both toes were black, and the large toe of the right foot has healed up fairly well, not so the toe on the left foot, and there is quite a black area, also slight arterial sclorosis. Is amputation of the toe advisable? Is it dibetic gangrene or a frost bite or burning of the toe?

Dr. Lehmann.— I don't think it is very much difference what it is. It is necrosis going on in a patient that has diabetes. What are the condition of the blood vessels? If they are in good condition I would say amputate the toe under local anaesthetic. If the blood vessels are not in good shape you would have to go up much higher than the toe. Many surgeons would refuse to amputate gangrenous toes in diabetic cases, and insist on amputating the leg. The resistance of the tissues was so inferior that it is found necessary to go as high as the thigh often. Diabetics stand general anaesthesia very badly and there is no reason why that couldn't be absolutely painlessly operated with local anaesthesia.

Dr. Jones.—Would it be a good thing to put that toe in a saline solution, which would keep it in a healthy condition, and give it some nourishment so it wouldn t progress as rapidly as it otherwise would?

Dr. Sharpe.—That condition isn't progressing rapidly, very little change for six weeks. The bone is exposed and roughened. The ar-

teries are not good.

Dr. Galloway.—How would Bier's congestion treatment be adapted to that, Dr. Lehmann?

Dr. Lehmann.—There would be disadvantages to that on account of the marked arterial sclerosis. I don't think a very good hyperaemia could be produced on account of the sclerosis.

Dr. Sharpe.—Would you leave this toe alone and watch it for results? As hyperaemic treatment has been suggested, would it be advisable to try the hot air treatment?

Dr. McKenty.—I think Dr. Sharpe's suggestion to leave it alone is the right one, if it is progressing all right.

Dr. MacKay.—As the diabetic sclerosis is increasing each day I would suggest that the operation be performed now rather than any delay.

Dr. Sharpe.—He has been under medical treatment for three weeks.

Dr. McKenty.—I would suggest continuing that treatment for two months, and perhaps the condition will disappear.

GENERAL MEDICAL NEWS

MEDICAL NEWS

The Annual Report of the Victoria Hospital, Prince Albert, showed that it is on a sound business basis. 246 patients have been treated during 1908 at an average cost of $1.73½ per day as compared with $1.99 in 1907. Of the 246 cases, 21 died, 3 being serious injuries. Of 95 typhoid, 11 deaths. The Ladies' Aid raised about $1000 for funds during 1908. Miss Shannon, the Matron, is resigning her position much to the regret of the directors.

The Civic Finance Committe of Vancouver recommended to the Council that grant to the Vancouver General Hospital be based on a per capita allowance of 40 cents per day. That this plan be followed for the next three years. The Committee has requested the comptroller to secure reports and statistics from other cities about the size of Vancouver with reference to their hospital work and the manner in which the municipalities contribute to their support.

The Associated Charities of Vancouver intend to take steps to secure funds for the building of an Infirmary Ward in connection with the hospital for convalescent patients.

An Order in Council has been passed defining the regulations for sale of patent medicines under an act of last session. A special stamp is to be provided by the department for goods in stock at the time the Act comes into force and will be supplied from March 1st to April 15th to all applying at the rate of two cents for 100 stamps. These are to be attached so that they seal the package. All medicine containing cocaine shall have attached these departmental stamps.

The Registrar of the British General Medical Council advises all medical practitioners that if they have not received an enquiry form for the revision of the Register they should communicate at once, otherwise their names may be omitted.

Delegates of the citizens of Victoria are to interview the Provincial Government on the 13th in regard to the selection of a site for the proposed B. C. University.

A handsome bath-house is to be erected shortly on English Bay and a life-saving service is to be established there.

McGill University received February 10th $100,000 from an anonymous donor on the condition that an additional $500,000 be raised. No time limit is set for the collection. Already $100,000 towards the half million has been collected.

An order has been received from Ottawa that seamen from coasting vessels are not in future to be admitted to the marine hospital—only those from foreign going ships. This has provoked much adverse comment.

The Manitoba Medical Association meets at Brandon June 22nd and 23rd. It is hoped that all western men who possibly can will attend, as many important matters will be discussed.

The Canadian Medical Conference will be held in Winnipeg August 21st and 22nd. The western men are particularly asked to contribute papers. Any willing to do so, please notify the Secretaries of the sections. The names of the various Secretaries were published in the January Journal.

A great bazaar is to be held in Edmonton to aid the new hospital. The Ladies' Aid have pledged themselves to raise $50,000.

Dr. Doherty, Medical Superintendent for the B| C Hospital for the Insane, states in his Annual Report that 230 patients were received during the year—70 per cent. of which were foreign born and about 30 per cent. has been less than two years in Canada. Several improvements have been made to the institution during the year—an additional private ward, a new laboratory, as well as a temporary building at the Colony Farm.

Lady Aberdeen has been carrying on propaganda for the improvement of the health of Ireland. She has undertaken the editorship of "Slanite"—a monthly magazine, which is

to be issued by the Women's National Health Association.

Peachland, B. C., has had an epidemic of typhoid recently. The Provincial health authorities are to make investigation into the sanitary conditions.

$600 has been set aside by the University Council of Manitoba for a travelling scholarship. The regulations are to be found in the Calendar for 1908-1909.

A Church and Medical Union of England has just been formed to promote the co-operation of the clergy and the medical profession. The Union has temporary offices in Dryden House, Gerrard St., W.

Sir John Williams, the great obstetrician, has shown his patriotism by handing over a very valuable collection of 20,000 Welsh books to the National Library of Wales.

PERSONALS

Dr. R. G. Brett of Banff has consented to accept the leadership of the conservative party of Alberta and will contest the constituency of Banff. Dr. Brett was formerly leader of the opposition in the N. W. Legislature and was one of the best known of public men of earlier days.

Dr. Blow is one of the nominees of the conservative party.

Dr. Hugh Cochrane, Maryfield, Sask., is taking a vacation, visiting friends in Sunbury and Kingston, Onario.

Dr. J. T. Whyte has returned from Chicago, where he attended post-graduate classes.

Dr. Ernest Hall of Vancouver has been visiting Winnipeg.

Dr. Hart of Indian Head has been on a visit to the East.

Dr. Blanchard, the President of the Canadian Medical Association, has returned from the East, where he has been making arrangements for the meeting in Winnipeg August 21st to 25th.

Dr. Mewburn of Lethbridge has been visiting Calgary.

Dr. Woollard, of Winnipeg, who has been in the service of

the Canadian-Australian Co. for over two years, was presented with a travelling clock and inkstand by the captain, officers and engineers of his ship in recognization of the high regard in which he was held. Whilst making the voyage South last summer, he distinguished himself at Xmas Island in his efforts to reach the ship wrecked people from the unfortunate steamer Aeon. The Australian papers all commended highly his courageous action. Dr. Woollard is to take a holiday in England before resuming his practice in Winnipeg.

Dr. R. Boucher, who left Phoenix, B. C., 2 years ago to take post-graduate courses in Austria and England, has decided to settle in Vancouver.

Death rate of Vancouver for 1908: 9.816 as against a record of 13.059 for 1907. Whites, 12.909, Orientals, 14.003.

Dr. H. L. Burris has left Vermillion, Alta., and settled in Kamloops, B. C.

Dr. W. J. Waugh, 1426 E. Ravenwood Park, Chicago, Ills., would be pleased of any information regarding Atropine as a Hemostatic.

The following have been appointed Coroners in Saskatchewan: Dr. Johanesson, Leslie: Dr. Hixon, Watrous; Dr. McLean, Lang, and Dr. Warren, Lanigan.

BORN

At Cupar—To Dr. and Mrs. Stuart a daughter, March 8th.

At Winnipeg—To Dr. and Mrs. Thompson a son, March 5th.

MARRIED

CLUFF—POWER.—At Toronto, January 14th, Dr. A. Cluff of Winnipeg was married to Miss Alice Power, daughter of Mr. R. Power of Toronto.

HART—HANCE.—At London, Ont., Miss Minnie Louisa Hance, daughter of Mr. and Mrs. John Hance of London, Ont., became the bride of Frederick William Hart, M.D., of Indian Head, Sask.

MARGOLESE—ROSENBLAT.—At Winnipeg, Miss Pearl Rosenblat was married to Dr. Oscar Margolese, son of Mr. and Mrs. J. Margolese of Montreal. The ceremony was performed by Rev. Mr. Lesvine.

CORRESPONDENCE

To the Editor of the Western Canada Medical Journal.

Dear Sir,—

I was greatly disappointed at the practical failure of Dr. Roddick's effort's to bring about Dominion Registration.

Then came the proposal for reciprocity among the four Western Provinces, which was sacrified to petty jealousies. I have sufficient faith in the ability and integrity of the members of all the Western Councils to think that a person who by one Council is declared competent to practice in that particular province is competent to practice in any or all of the other three. But apparently the members of the various Councils are otherwise minded.

Now comes Dr. Kennedy with a proposition to which, it seems to me, even the narrowest provincialism cannot offer any valid objection. By all means let us attempt to have his suggestion carried out. With Dr Patterson, I think the Brandon meeting (June 22-23) is the one at which it should be brought forward. I hope all four Councils will send delegates empowered to act. Then. when a feasible scheme has been agreed upon by the delegates, submit it to a plebescite of the four Provinces.

I do not expect all the Provinces to adopt even that degree of reciprocity at once; but if only two will adopt it, by all means let them do so, the others will follow sooner or later.

May success crown your laudable efforts to secure reciprocity

E. C. Arthur, A.M., M D.

Nelson, B.C., Feb. 20th, 1909

NOTICE

ODD-NUMBERED SECTIONS

As already publicly announced, odd numbered sections remaining vacant and undisposed of will become available for homestead entry on the coming into force of the Dominion Lands Act on Sept. 1, next.

As the records of only the even numbered sections have hitherto been kept in the books of the various land agencies in the western provinces and the time having been very limited since the passing of the act within which to transfer the records of all odd numbered sections from the head office at Ottawa to the local offices, it is possible that the transfer of records in some cases may not have been absolutely completed by the 1st September. In any case where the record of any quarter section has not been transferred, application will be accepted but will have to be forwarded to head office to be dealt with.

As it has been found impossible as yet to furnish sub-agencies with copies of the records of the odd numbered sections and in view of the large probable demand for entries, all applicants for entry upon odd numbered sections are strongly advised to make their applications in person at the office of the Dominion Lands Agent and not through a Sub Land Agent. Applications for even numbered sections may be dealt with through the Sub-Land Agent as before if desired.

J. W. GREENWAY,

Commissioner of Dominion Lands,
Winnipeg, August 22, 1908.

Synopsis of Canadian North-West Homestead Regulations

Any even numbered section of Dominion lands in Manitoba, Saskatchewan and Alberta, excepting 8 and 26, not reserved, may be homesteaded by any person who is the sole head or a family, or any male over 18 years of age, to the extent of one-quarter section of 160 acres more or less.

Application for entry must be made in person by the applicant at a Dominion Lands Agency or Sub-Agency for the district in which the land is situate. Entry by proxy, may, however, be made at an Agency on certain conditions by the father, mother, son, daughter, brother or sister of an intending homesteader.

DUTIES:

(1) At least six months' residence upon and cultivation of the land in each year for three years.

(2) A homesteader may, if he so desires, perform the required residence duties by living on farming land owned solely by him, not less than eighty (80) acres in extent, in the vicinity of his homestead. Joint ownership in land will not meet this requirement.

(3) A homesteader intending to perform his residence duties in accordance with the above while living with parents or on farming land owned by himself must notify the Agent for the district of such intention.

Six months' notice in writing must be given to the Commissioner of Dominion Lands at Ottawa, of intention to apply for patent.

W. W. CORY,

Deputy of the Minister of the Interior.

N.B.—Unauthorized publication of this advertisement will not be paid for.